MARYLAND APPLICATION FOR PSYCHOLOGY ASSOCIATE

Maryland Board of Examiners of Psychologists
4201 Patterson Avenue
Baltimore, Maryland 21215
410-764-4787
Fax: 410-358-7896
www.dhmh.md.gov/psych

FOR OFFICE USE ONLY

APPROVAL DATE_____

REVIEWER: _____

DATE REVIEWED:_____

COMMENTS:_____

TYPE OR PRINT ALL INFORMATION ***APPLICATION FEE $100.00 (NON-REFUNDABLE)***

THIS SECTION TO BE COMPLETED BY THE PSYCHOLOGY ASSOCIATE

Full Name:	Social Security Number:
Work Address:	Home Address:
Work Phone Number:	Home Phone Number:
Email Address:	

OFFICIAL TRANSCRIPTS MUST BE SENT FROM SCHOOLS

Highest Degree Earned:	From	To	School:	Program/Department:
Other Degree Earned:	From	To	School:	Program/Department:
Other Degree Earned:	From	To	School:	Program/Department:

Employment (list most recent first)

Name and Address of Facility:	From: To:
Your Title:	No. of Hours worked per week:
Name and Address of Facility:	From: To:
Your Title:	No. of Hours worked per week:

Are you licensed, certified, or registered by any governmental agency or government Board in any state, county or jurisdiction?
☐ Yes ☐ No (If yes explain)

Have you ever been investigated or charged with unethical practices or unprofessional conduct, or are you presently being investigated or under charges?
☐ Yes ☐ No (If yes, submit a certified copy of your criminal history record)

I assert that the information contained in this application is true to the best of my knowledge and belief.

Applicant's Signature: _____ Date: _____

THIS SECTION TO BE COMPLETED BY THE LICENSED PSYCHOLOGIST

Name:		
Work Address:		
Maryland License Number:	Date of Initial Licensure:	
Work Phone Number:	Email:	
Highest Degree Earned:	School:	Program Specialty: Practice Specialty:

Provide the names of the psychology associates that are currently working under your license. Include the number of client hours that they work and the amount of face-to-face supervision that you provide **per week** for both client services and testing (Regulation 10.36.07.05 B (4) (6), requires an additional hour of supervision for each five (5) hours of testing).

Current Psychology Associates	**# of Client Hours** (exclude testing):	**# of Hours Supervision**	**# of Testing Hours**	**# of Hours Supervision**
TOTALS				

List the Psychology Associate to be added.

New Psychology Associate	**# of Client Hours** (exclude testing):	**# of Hours Supervision**	**# of Testing Hours**	**# of Hours Supervision**

Describe other duties to be performed by the Psychology Associate:

List name and address where services will be provided:

If address is different than your work address please explain:

Describe how the supervision will occur:

At what location will the supervision occur?

I understand that the psychology associate is permitted to provide psychological services under the authority of my license. Therefore, I understand that I will be held accountable in the event that a professional, ethical, or legal issue arises pertaining to psychological services being rendered by a psychology associate. I am aware that I am required to provide face to face supervision to the psychology associate as specified in COMAR 10.36.07.05. I also agree to inform all clients, when applicable, that they are being treated by a psychology associate whose work I supervise. I will conform to the standards for supervisory relationships as established by the Maryland Board of Examiners of Psychologists, COMAR 10.36.07 and understand that the Board must be informed in writing when a psychology associate relationship is terminated.

I assert that the information contained in this application is true to the best of my knowledge and belief.

Supervisor's Signature: _____ Date: _____